INSTRUCTIONS FOR COMPLETING THE STANDARD TORT CLAIM FORM

Pursuant to RCW 4.96.020, these instructions are for filing a Tort Claim Form against Public Hospital District No. 1 of Grant County d/b/a Samaritan Healthcare (the "District").

Before filing a Tort Claim against the District, please read the following instructions:

- TYPE OR PRINT CLEARLY IN INK.

- Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries.

- If the requested information cannot be supplied in the space provided, please use additional blank sheets.

- The following are examples on how to complete the Standard Tort Claim Form:

1. Smith, Jane Doe, 01/01/1234
2. 1234 E. Eden Road, Moses Lake, WA 98837
3. P.O. Box 0000, Moses Lake, WA 98837
4. Same
5. 509/123-4567
6. Janedoesmith@email.com
7. January 1, 1990, 12:00 p.m.
8. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 7.
9. Grant County, WA, Wheeler Road
10. Wheeler Road
11. Jane Doe Smith, 1234 E. Eden Road, Moses Lake, WA 98837, 509/123-4567
12. List all District employees having knowledge of the incident in question.
13. List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 12 and 13. Also include a description of their knowledge.
14. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why. In addition, please explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.
15. If you reported this incident to law enforcement or any hospital staff or employees, please provide a copy of the report or contact information to the person(s) you spoke with.

16. Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
17. Please attach documents which support the claim allegations.
18. Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss, etc. This amount should represent your opinion of total compensation.
19. Please sign the form, and also put the date you signed the form and where you signed the form

ONCE THIS FORM IS COMPLETED, PRESENT IT TO THE AGENT OF RECORD FOR THE DISTRICT. THE IDENTITY AND CONTACT INFORMATION OF THE AGENT OF RECORD IS ON FILE AT THE OFFICE OF THE GRANT COUNTY AUDITOR, AND IS ALSO PROVIDED IN THE TORT CLAIM PACKET.

STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Public Hospital District No. 1, Grant County, Washington, d/b/a Samaritan Healthcare (the "District"). Some of the information requested on this form is required by RCW 4.96.020 and is subject to public disclosure pursuant to RCW 42.56.

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original Tort Claim Form to

Kurt Kuykendall, Director of Quality & Risk Management
Public Hospital District No. 1 of Grant County
801 East Wheeler Road
Moses Lake, WA, 98837

Business Hours: Monday – Friday 8:00 a.m. – 5:00 p.m.
Closed weekends and holidays.

1. Claimant's name:_____
Last name First Middle Date of birth

2. Current residential address:_____

3. Mailing address (if different):_____

4. Residential address at the time of the incident:_____
(if different from current address)

5. Claimant's daytime telephone number:_____ _____
Home Business/Cell

6. Claimant's e-mail address:_____

7. Date of the incident:_____ Time: ☐ a.m. ☐ p.m. (check one)
(mm/dd/yyyy)

8. If the incident occurred over a period of time, date of first and last occurrences:

from:_____ Time: ☐ a.m. ☐ p.m.
(mm/dd/yyyy)

to:_____ Time: ☐ a.m. ☐ p.m.
(mm/dd/yyyy)

9. Location of incident:_____

State and County City, if applicable Place where occurred

10. If the incident occurred on a street or highway:

_____

Name of street or highway Milepost number At the intersection with or nearest intersecting street

11. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

12. Names, addresses and telephone numbers of all District employees having knowledge about this incident:

13. Names, addresses and telephone numbers of all individuals not already identified in #11 and #12 above that have knowledge regarding the liability issues involved in this incident, or knowledge of the Claimant's resulting damages (Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary):

14. Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries (Attach additional sheets if necessary):

15. State whether this incident has been reported to law enforcement, or any District employee (If so, when and to whom? Please attach a copy of the report or contact information):

16. Names, addresses and telephone numbers of treating medical providers (Attach copies of all medical reports and billings):

17. Please attach documents which support the allegations of the claim.

18. I claim damages from the District in the sum of $_____.

This Standard Tort Claim Form must be completed and signed by the Claimant, a person holding a written power of attorney from the Claimant, by the attorney in fact for the Claimant, by an attorney admitted to practice in Washington State on the Claimant's behalf, or by a court-approved guardian or guardian ad litem on behalf of the Claimant.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

_____	_____
Signature of Claimant	***Date and place (Residential address, city, and county)***
Or	
_____	_____
Signature of Representative	***Date and place (Residential address, city, and county)***
_____	_____
Print Name of Representative	***Bar Number (if applicable)***